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8 **BEFORE THE**  
9 **BOARD OF REGISTERED NURSING**  
10 **DEPARTMENT OF CONSUMER AFFAIRS**  
**STATE OF CALIFORNIA**

11 In the Matter of the Accusation Against:

Case No. *2013-472*

12 **KRISTOFFER PUNONGBAYAN**  
13 **GONZALEZ**

615 Pearson Road  
Port Hueneme, CA 93041

**ACCUSATION**

14 Registered Nurse License No. 651959

15 Respondent.  
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18  
19 Complainant alleges:

20 **PARTIES**

21 1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her  
22 official capacity as the Executive Officer of the Board of Registered Nursing, Department of  
23 Consumer Affairs (Board).

24 2. On or about February 3, 2005, the Board issued Registered Nurse License No.  
25 651959 to Kristoffer Punongbayan Gonzalez (Respondent). The Registered Nurse License was in  
26 full force and effect at all times relevant to the charges brought herein and will expire on April 30,  
27 2014, unless renewed.  
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1 Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as  
2 defined in Section 4022.

3 "(b) Use any controlled substance as defined in Division 10 (commencing with Section  
4 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in  
5 Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to  
6 himself or herself, any other person, or the public or to the extent that such use impairs his or her  
7 ability to conduct with safety to the public the practice authorized by his or her license.

8 . . . .

9 "(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any  
10 hospital, patient, or other record pertaining to the substances described in subdivision (a) of this  
11 section."

12 8. Section **2764** provides that the expiration of a license shall not deprive the Board of  
13 jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision  
14 imposing discipline on the license. Under section 2811, subdivision (b), the Board may renew an  
15 expired license at any time within eight (8) years after the expiration.

16 9. Health and Safety Code section **11173** states, in pertinent part:

17 "(a) No person shall obtain or attempt to obtain controlled substances, or procure or attempt  
18 to procure the administration of or prescription for controlled substances, (1) by fraud, deceit,  
19 misrepresentation , or subterfuge; or (2) by the concealment of a material fact.

20 (b) No person shall make a false statement in any prescription, order, report, or record,  
21 required by this division."

22 10. Health and Safety Code section **11350**, subsection (a) states, in pertinent part:

23 "Except as otherwise provided in this division, every person who possesses (1) any  
24 controlled substance specified in subdivision (b) or (c), or paragraph (1) of subdivision (f) of  
25 Section 11054, specified in paragraph (14), (15), or (20) of subdivision (d) of Section 11054, or  
26 specified in subdivision (b) or (c) of Section 11055, or specified in subdivision (h) of  
27 Section 11056, or (2) any controlled substance classified in Schedule III, IV, or V which is a  
28 narcotic drug, unless upon the written prescription of a physician, dentist, podiatrist, or

1 veterinarian licensed to practice in this state, shall be punished by imprisonment pursuant to  
2 subdivision (h) of Section 1170 of the Penal Code.”

### 3 REGULATORY PROVISION

4 11. California Code of Regulations, title 16, section 1442 states:

5 "As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from  
6 the standard of care which, under similar circumstances, would have ordinarily been exercised by  
7 a competent registered nurse. Such an extreme departure means the repeated failure to provide  
8 nursing care as required or failure to provide care or to exercise ordinary precaution in a single  
9 situation which the nurse knew, or should have known, could have jeopardized the client's health  
10 or life."

### 11 COST RECOVERY

12 12. Section 125.3 provides, in pertinent part, that the Board may request the  
13 administrative law judge to direct a licentiate found to have committed a violation or violations of  
14 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and  
15 enforcement of the case.

### 16 CONTROLLED SUBSTANCES / DANGEROUS DRUGS

17 13. Section 4021 of the Code states: "Controlled substance" means any substance listed in  
18 Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety Code.

19 14. Section 4022 of the Code states: "Dangerous drug" or "dangerous device" means any  
20 drug or device unsafe for self-use, except veterinary drugs that are labeled as such, and includes  
21 the following:

22 (a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without  
23 prescription," "Rx only," or words of similar import.

24 (b) Any device that bears the statement: "Caution: federal law restricts this device to sale by  
25 or on the order of a , " "Rx only," or words of similar import, the blank to be filled in 'with the  
26 designation of the practitioner licensed to use or order use of the device.

27 (c) Any other drug or device that by federal or state law can be lawfully dispensed only on  
28 prescription or furnished pursuant to Section 4006."

15. **Dilaudid**, a brand name **Hydromorphone**, is an Opium derivative classified as a Schedule II Controlled Substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(J), and categorized as a dangerous drug pursuant to section 4022.

16. **Oxycontin**, a brand name for **Oxycodone (Percocet)** , is a narcotic used for relief of moderate to severe pain classified as a Schedule II controlled substance pursuant to Health and Safety Code Section 11055 , subdivision (b)(1)(M), and categorized as a dangerous drug pursuant to section 4022.

17. **Morphine**/Morphine Sulfate (extended release **MS Contin**), a narcotic substance classified as a Schedule II controlled substance pursuant to Health and Safety Code Section 11055(b)(1)(L), and categorized as a dangerous drug pursuant to section 4022.

18. **Restoril**, a brand name for **Temazepam**, is a benzodiazepine used for the relief of anxiety, panic attacks and chronic sleeplessness, classified as a Schedule IV controlled substances pursuant to Health and Safety Code Section 11057(d)(29), and categorized as a dangerous drug pursuant to section 4022.

19. **Dolophine**, a brand name for **Methadone**, a narcotic pain reliever, is a Schedule II controlled substance as designated by Health and Safety Code section 11055(c)(14), and a dangerous drug per Business and Professions Code section 4022.

20. **Hydrocodone with Acetaminophen**, also known as **Vicodin or Norco**, is a Schedule III controlled substance pursuant to Health and Safety Code section 11056(e)(4), and a dangerous drug within the meaning of Code section 4022.

### FIRST CAUSE FOR DISCIPLINE

**(False Records)**

21. Respondent is subject to disciplinary action under section 2761, subdivision (a), and 2762, subdivisions (a), (b) and (e), on the grounds of unprofessional conduct and falsifying healthcare documents, in that on or about October 1, 2008, through on or about December 1, 2008, while on duty as a registered nurse at Saint John's Medical Center, Oxnard, California (SJMC), Respondent falsified, or made grossly incorrect, grossly inconsistent, or unintelligible entries in hospital, patient, or other record pertaining to controlled substances for patients, as

1 follows:

2 a. On or about November 21, 2008, B. H.<sup>1</sup>, the Nurse Manager of SJMC discovered that  
3 the Respondent withdrew Dilaudid from SJMC's Pyxis<sup>2</sup> dispensary allegedly on behalf of a  
4 patient that was not assigned to him. Respondent was never assigned to that patient nor were  
5 there physician orders in place authorizing the Respondent to withdraw and administer Dilaudid  
6 for this patient. When B.H. questioned the Respondent about the aforementioned withdrawal,  
7 Respondent showed the withdrawn Dilaudid by removing it from his lab coat pocket. Respondent  
8 claimed that he mistakenly placed the wrong patient identification number in the Pyxis and that  
9 he supposedly meant to withdraw the related Dilaudid on behalf of another patient who was  
10 assigned to him. Respondent claimed that when he attempted to administer the related Dilaudid  
11 to the correct patient, this patient was supposedly asleep, therefore, he then "stored" the Dilaudid  
12 in his lab coat pocket, therefore, Respondent would not have to waste it. However, once  
13 Respondent realized his patient did not need the medication or that the medication was not  
14 ordered for his patient, Respondent should have wasted the medication. Respondent was  
15 reprimanded for not following the proper SJMC's protocols via the requirement to waste all  
16 unused controlled substances.

17 b. Respondent violated SJMC's policy and procedures in his possession of Dilaudid in  
18 his pocket, his failure to follow the "8 rights"<sup>3</sup> of medication administration, and his failure to  
19 properly waste (with witness) said medication.

20 c. Respondent was placed on investigation suspension and was ordered to submit to a  
21 SJMC's drug screening. The screening revealed that the Respondent tested positive for  
22 Amphetamines in his drug screen. Accordingly, the Respondent was terminated from SJMC.

23 d. On or about November 25, 2008, SJHC administration conducted a random audit of

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24 <sup>1</sup> In order to protect the privacy of the individual, the initials of her first and last name will be used

25 <sup>2</sup> Pyxis is an automated and computerized medication dispensing system. Medications are placed in the  
26 Pyxis machines, which are usually stationed throughout the hospital. These medications can only be accessed or  
27 withdrawn by an authorize staff member using their own unique personalized access code. Each medical  
28 professional at the hospital is assigned an account number and a "one time only" access code number. The access  
code number allows the individual to access the Pyxis machine only one time.

<sup>3</sup> One of the rights is the "right documentation"

1 Respondent's controlled substance and dangerous drug withdrawals from the hospital's Pyxis  
2 dispensary. The audit revealed that the Respondent diverted controlled substances from SJMC  
3 from approximately October 5, 2008 through November 25, 2008, and did not document twelve  
4 (12) controlled substance medications that he removed from the Pyxis machine.

5 e. The Nurse Manager of SJMC, B.H., reported that Respondent removed two (2) mg  
6 of Morphine for a patient that was assigned to a licensed vocational nurse. Said patient had not  
7 had any morphine documented or removed for this admission prior to this event. Further, the date  
8 the Respondent removed the two (2) mg of Morphine for this patient was the day of patient's  
9 discharge. B.H. telephoned the patient in question at home and when asked about the medication  
10 she received during her last admission to SJMC, the patient indicated that she did not receive any  
11 Morphine, only Percocet for pain. B.H. noted that Morphine removed from Pyxis by the  
12 Respondent allegedly for the patient in question, was not documented in the patient's medical  
13 record or documented as wasted.

14 f. Respondent was accepted into the Board of Registered Nursing's Diversion Program  
15 (Diversion Program) on or about December 5, 2008. However, he withdrew from the Diversion  
16 Program on or about March 12, 2009, without any explanations.

17 g. Respondent failed to respond to the investigator's (Division of Investigation) multiple  
18 attempts to make contact for an interview.

19 h. **Patient # 83831073**

20 1) On or about October 17, 2008, at approximately 20:14 hours Respondent withdrew  
21 forty (40) mg of Methadone for Patient # 83831073 from SJMC's Pyxis dispensary. However,  
22 Respondent made no entries in the patient's MAR<sup>4</sup> or in the nursing notes, and there was no  
23 documentation of wastage, therefore the forty (40) mg of Methadone remains unaccountable for  
24 in any hospital records.

25 2) The total discrepancies of the controlled substance for this patient are forty (40) mg of  
26 Methadone.

27 \_\_\_\_\_  
28 <sup>4</sup> Medication Administration Record

1           i.     **Patient # 83800193**

2           1)     On or about October 5, 2008, at approximately 22:11 hours Respondent withdrew two  
3     (2) tablets of Oxycodone/APAP 5/325 for Patient # 83800193 from SJMC's Pyxis dispensary.  
4     However, he made no entries in the patient's MAR or in the nursing notes, and there was no  
5     documentation of wastage, therefore the two (2) tablets of Oxycodone/APAP 5/325 remains  
6     unaccountable for in any hospital records.

7           2)     The total discrepancies of the controlled substance for this patient are two (2) tablets  
8     of Oxycodone.

9           j.     **Patient # 83848697**

10          1)     On or about October 25, 2008, at approximately 5:53 hours, Respondent withdrew  
11     two (2) mg of injectable Morphine for Patient # 83848697 from SJMC's Pyxis dispensary.  
12     However, he made no entries in the patient's MAR or in the nursing notes, and there was no  
13     documentation of wastage, therefore the two (2) mg of injectable Morphine remains  
14     unaccountable for in any hospital records.

15          2)     The total discrepancies of the controlled substance for this patient are two (2) mg of  
16     injectable Morphine.

17          k.     **Patient #83822491**

18          1)     On or about October 22, 2008, at approximately 4:31 hours, Respondent withdrew  
19     two (2) tablets of Hydrocodone/APAP 5/500 (Vicodin) for Patient # 83822491 from SJMC's  
20     Pyxis dispensary. Respondent documented in the "Daily Patient Assessment Flowsheet" the  
21     administration of one tablet of Vicodin on October 22, 2008, at 4:30 hours to Patient # 83822491.  
22     However, Respondent failed to document administration in the patient's MAR or in the "Daily  
23     Patient Assessment Flowsheet" or any other nursing notes the administration of the one (1)  
24     remaining tablet of Vicodin, and there was no documentation of wastage, therefore, one (1) tablet  
25     of Vicodin (Hydrocodone/APAP 5/500) remains unaccountable for in any hospital records.

26          2)     The total discrepancies of the controlled substance for this patient are one (1) tablet of  
27     Vicodin.  
28



1           1.    **Patient #83839944**

2           1)    On or about October 22, 2008, at approximately 21:59 hours, Respondent withdrew  
3   7.5 mg of Temazepam (Restoril) for Patient # 83839944 from SJMC's Pyxis dispensary.  
4   However, he made no entries in the patient's MAR or in the nursing notes, and there was no  
5   documentation of wastage, therefore the 7.5 mg of Restoril remains unaccountable for in any  
6   hospital records.

7           2)    The total discrepancies of the controlled substance for this patient are 7.5 mg of  
8   Restoril.

9           m.   **Patient #87816660**

10          1)    On or about October 5, 2008, at approximately 6:22 hours, Respondent withdrew one  
11   (1) mg of injectable Hydromorphone (Dilaudid) for Patient # 87816660 from SJMC's Pyxis  
12   dispensary. However, he made no entries in the patient's MAR or in the nursing notes, and there  
13   was no documentation of wastage, therefore, one (1) mg of injectable Dilaudid remains  
14   unaccountable for in any hospital records.

15          2)    The total discrepancies of the controlled substance for this patient are one (1) mg of  
16   injectable Dilaudid.

17          n.   **Patient #83830992**

18          1)    On or about October 23, 2008, at approximately 5:09 hours, Respondent withdrew  
19   two (2) mg injectable Morphine for Patient # 83830992. However, he made no entries in the  
20   patient's MAR or in the nursing notes, and there was no documentation of wastage, therefore, two  
21   (2) mg injectable Morphine remains unaccountable for in any hospital records.

22          2)    On or about October 23, 2008, at approximately 00:50 hours, Respondent withdrew  
23   two (2) tablets of Oxycodone/APAP 5/325 for Patient # 83830992. However, he made no entries  
24   in the patient's MAR or in the nursing notes, and there was no documentation of wastage,  
25   therefore, two (2) tablets of Oxycodone/APAP 5/325 remains unaccountable for in any hospital  
26   records.

27          2)    The total discrepancies of the controlled substance for this patient are two (2) tablets  
28   of Oxycodone/APAP 5/325 and two (2) mg injectable Morphine.

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2) Respondent obtained and/or possessed controlled substances in violation of law;

3) Respondent tested positive for Amphetamines on his drug screen of November 25, 2008, without having valid prescriptions;

4) Respondent violated SJMC's policy and procedures in his possession of Dilaudid in his pocket, his failure to follow the "8 rights"<sup>5</sup> of medication administration, and his failure to properly waste (with witness) said medication. An ordinary prudent responsible registered nurse is well aware of strict adherence to policy and the severe consequences that improperly handling controlled substances can result. When controlled substances are unaccountable in hospital records, it essentially means diversion;

5) Respondent violated SJMC's policy and procedures in his possession of Dilaudid in his pocket, his failure to follow the "8 rights"<sup>6</sup> of medication administration, and his failure to properly waste (with witness) said medication. When confronted by B. H., the Nurse Manager of SJMC, Respondent had in his pocket Dilaudid he withdrew from Pyxis for a patient he was not assigned to. Respondent did not administer or waste the medication (Dilaudid), as per SJMC's policy and procedures;

6) Respondent failed to follow the proper controlled substance medication administration practices.

Complaint refers to and by this reference incorporates the allegations set forth above in paragraphs 21-23, inclusive, as though set forth fully.

### FIFTH CAUSE FOR DISCIPLINE

**(Unprofessional Conduct)**

25. Respondent is subject to disciplinary action under section 2761, subdivision (a), in that Respondent committed acts of unprofessional conduct. Complaint refers to and by this reference incorporates the allegations set forth above in paragraphs 21-24, inclusive, as though set forth fully.

<sup>5</sup> One of the rights is the “right documentation”

<sup>6</sup> One of the rights is the “right documentation”

1 SIXTH CAUSE FOR DISCIPLINE

2 (Violation of Nursing Practice Act)

3 26. Respondent is subject to disciplinary action under section 2761, subdivision (d), on  
4 the grounds of unprofessional conduct, in that Respondent violated or attempted to violate,  
5 directly or indirectly, the provisions of the Nursing Practice Act as set forth in paragraphs 21-23.  
6 Complaint refers to and by this reference incorporates the allegations set forth above in  
7 paragraphs 21-25, inclusive, as though set forth fully.

8 PRAYER

9 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,  
10 and that following the hearing, the Board of Registered Nursing issue a decision:

- 11 1. Revoking or suspending Registered Nurse License No. 651959 to Kristoffer  
12 Punongbayan Gonzalez;
- 13 2. Ordering Kristoffer Punongbayan Gonzalez to pay the Board the reasonable costs of  
14 the investigation and enforcement of this case, pursuant to section 125.3; and,
- 15 3. Taking such other and further action as deemed necessary and proper.
- 16

17 DATED: December 10, 2012

18 *for* LOUISE R. BAILEY, M.ED., RN  
19 Executive Officer  
20 Board of Registered Nursing  
21 Department of Consumer Affairs  
22 State of California  
23 Complainant  
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